APPENDIX B (con't)
MEDICAL INSURANCE – MANAGED CARE

	Coordinate Care "In Network"	Self-Referred "In or Out-of-Network
Mental Health Inpatient Outpatient	 100% 100%	 80% after deductible 50% after deductible
Substance Abuse (PA mandated benefits indicated below) Inpatient Detoxification Rehabilitation Outpatient	 100% 7 days admission 4 admissions per lifetime 100% 30 days/year 90 days/lifetime 100% 60 visits/year 120 visits/lifetime	 80% after deductible 7 days admission 4 admissions per lifetime 80% after deductible 30 days/year 90 days/lifetime 50% after deductible 60 visits/year 120 visits/lifetime
Skilled Nursing Care Facility	100%	80% after deductible Limit 50 days per year
Home Health Care	100%	80% after deductible Limit 50 visits/year
Private Duty Nursing	100%	80% after deductible Limit: $5,000/year
Pre-certification Requirements	Performed by Network Medical Management	Required for inpatient admission to non-participating hospital

**A female member may self-refer to a network OB/GYN of her choice for an annual gynecological examination, mammogram and PAP smear, as well as for maternity care.

Exhibit 1

APPENDIX B (con't)
MEDICAL INSURANCE – FEE FOR SERVICE

BLUE CROSS COVERAGE – HOSPITAL BENEFITS (Blue Cross benefits cover 100% of eligible inpatient and outpatient charges for services provided by hospitals and other participating health care facilities.)	
Inpatient Days	365 days per admission. A new admission begins 90 days after the discharge date.
Room Accommodations	Semi-private: Full allowance. Private Room: equal to the hospital's most common charge for semi-private rooms.
Hospital Ancillary Services	No dollar limit for services provided
Diagnostic Services	Covered as an inpatient
Outpatient: Emergency Accident Diagnostic X-rays Diagnostic Testing Diagnostic Laboratory Minor Surgery – Covered	 Covered within 72 hours $50 deductible. This deductible will not be eligible for reimbursement under Major Medical Benefits. No maximum, no deductible for specific covered tests No maximum, no deductible Radiation Therapy
Drug and Alcohol: Detoxification Rehabilitation Ambulatory	 7 days per admission, 4 admissions per lifetime 30 days per year, 90 days per lifetime 60 outpatient services per year, 120 services per lifetime
Skilled Nursing Facility Services	Covered – 2 days in a Skilled Nursing Facility equals 1 hospital day
Home Care Services	Covered – 100 visit per 12-month period
BLUE SHIELD COVERAGE – PHYSICIAN BENEFITS (Blue Shield Medical/ Surgical benefits cover eligible services provided by physicians and other health care professionals.)	
Surgical Operations... *Obstetrical Services including routine newborn care* *Oral Surgery* *Second Surgical Opinion* *Radiation Therapy* *Diagnostic X-ray Services* *Allergy Testing Anesthesia* *Shock Therapy*	Covered – Payment based on Usual Customary and Reasonable (UCR) charge
Medical and Osteopathic Care *Consultation Services* *Physical Therapy*	Covered in hospital only
Home and Office Calls	For employees only when they are unable to work - $25 deductible
Diagnostic Pathology	$100 maximum per calendar year for diagnostic pathology tests. Expenses in excess of $100 for these tests will be eligible for reimbursement under Major Medical benefits. (Standard deductible and co-insurance for Major Medical apply.)
Emergency Accident Care	Covered in or out of the hospital within 72 hours

Exhibit 1

APPENDIX B (con't)
MEDICAL INSURANCE – FEE FOR SERVICE

MAJOR MEDICAL	
Deductible	$250 per person – maximum of 3 per family
Co-insurance	After the deductible, 80% of the next $2,000 of eligible expenses covered, then 100% of excess eligible expenses covered
Out-of-Pocket Limit	Deductible + Co-insurance
Lifetime Maximum	$1,000,000 per person. Up to $1,000 automatically reinstated each January 1st
Private Room Allowance	Limited to the average semi-private room charge
Ambulance Expenses	Covered when medically necessary
Psychiatric Care Expenses: Inpatient Outpatient Maximum per Outpatient: Physician Visit Lifetime Maximum	 Patient is responsible for 20% Patient is responsible for 50% $40 (paid at 50% = $20) $10,000 – non-reinstatable

*Appendix B is only a summary of you Health Benefit Plans. Please refer to your Health Plan Booklet for specific details.

Exhibit 1